Public Health
Seattle & King County

**ESF 8 HAZARD ANNEX**

# Alternate Care Facilities Plan

Version 2 2012

## Record of Changes

| Version No. | Change Description | Date Entered | Posted By |
|---|---|---|---|
| 2 | Major revisions to entirety of plan | 2011-2012 | A. Kolberg |

Table of Contents

## I. Introduction

During an emergency there may be times when hospitals, ambulatory care or long-term-care facilities are not able to accommodate all those who need care. This could be due to a variety of reasons, including:

- Illness affecting a large proportion of the population (e.g. pandemic influenza)
- Increase in seriously ill and injured at hospitals creates the need for space to be freed up by moving more stable patients to be cared for elsewhere.
- Facility must close (e.g. extended power outage or damage from an earthquake)

Depending on the reason behind the reduced capacity, an Alternate Care Facility (ACF) will provide one or more types of care, including in-patient, ambulatory, and palliative care. In order to provide the expected level of care, Public Health Seattle & King County (Public Health) has created the following plan to manage the opening, running, and demobilization of an ACF, scalable to 250 in-patient and ambulatory care beds based on available manpower, resources, and type of care needed.

It will always be the first choice to secure medical and non-medical assets to allow patients to stay in place. The second option is moving patients to nearby like facilities that have the capacity to provide the patients the care they need. The third option is moving patients to like facilities outside of the county. The opening of an ACF should only be considered when all other options are unavailable or not feasible.

## II. Purpose

This plan exists to provide service to those who need medical assistance but due to an emergency are not able to receive it in the traditional environments of a hospitals or long-term-care facility. Public Health will use the plan to establish a care facility within 24 hours of becoming aware of the need.

## III. Scope

This plan operates under the assumption that there are different circumstances under which an ACF may be open, necessitating a modular approach to medical care and services.

Options for care provided includes:

- Simple wound management, including suturing
- Short-term fracture/ musculoskeletal injury management
- Oral or IV fluid resuscitations (e.g. for patients with nausea and vomiting)
- Non-narcotic prescription refill and authorization
- IV antimicrobial administration
- IV symptom relief (e.g. antiemetic)
- Short-term oxygen delivery
- Bronchodilator therapy/ peak flow assessment
- Oral medications (select)
- Pain management
- Limited laboratory

Options for patients able to be treated in an ACF include:

- Post-surgical patients anticipated ready for hospital discharge within 48 hours.

- Patients ready for discharge and awaiting a vacant bed at a long-term care facility or skilled nursing facility.
- Other patients without potentially life-threatening symptoms or vital signs
- Patients admitted primarily for IV antimicrobials and monitoring to ensure their condition does not worsen and who are expected to be discharged within 48-72 hours (e.g. patient with moderately severe cellulites without sepsis).
- Patients who are dying and for whom palliative care is indicated.

**Special Considerations**
Some patients will require treatment with a higher level of acuity than the ACF is able to provide. Such patients will be stabilized at the ACF until such time as they are able to be transported to a more appropriate facility. Patients who may fit this profile include:

- Patients who need continuous monitoring (arterial, venous, BP, cardiac, O2, frequent neurological checks, daily X-rays or imaging)
- Patients requiring intensive post-operative care
- Patients requiring special hospital equipment that is not available in the ACF
- Premature infants <36 weeks gestation
- Patients requiring intensive behavioral health assistance for conditions such as severe dementia or delirium, or who meet the criteria for involuntary psychiatric commitment as determined by a designated mental health professional

Patients with behavioral health needs will be accommodated in the ACF so long as the treatment they require does not exceed the capabilities of the facility. Such needs that can be met include:

- Patients with dementia or delirium who do not require any type of restraint or locked ward for aggressive behavior
- Persons who have a medical condition and present with symptoms indicating mental illness or chemical abuse/dependency and are:
  - Able to comply with medical and psychiatric treatment
  - Able to follow instruction and direction by the ACF staff and volunteers
  - Able to abstain from consuming alcohol and/or non-prescribed drugs
  - Not disruptive to the delivery of care to themselves or others in the ACF

Attachments

## IV. Situation Overview

While there may be many different reasons to open an ACF, the type of opening comes in two main forms: Long-Term Care Facility Support and Hospital Support.

**Long Term Care Facility Support**
Patients cared for in an ACF opened as a result of an evacuating long-term care facility (including nursing homes and adult family homes) are not necessarily presenting with an acute or new medical condition but require some medical surveillance and/or special assistance beyond what is available in a general population shelter.

The following should be expected of an ACF activated for this type of support:

- Inpatient unit activated
- Pharmacy and lab capabilities may be activated
- Emergency stabilization capabilities (patients with complex medical care transported elsewhere)
- 50 inpatient bed minimum, 200 inpatient bed maximum, increasing in 50-bed increments
- Staffing includes personnel from the evacuating facility

Example of reason for activation:

- A long-term care facility experiences a power outage and the ambient air temperature in the facility is above 75 degrees, with a need to evacuate and without other long-term care facilities able to absorb all of the patients.

**Hospital support**

The inpatient care unit of the ACF would be activated in response to a significant loss of regional inpatient capacity, a surge in the number of patients with illnesses or injuries due to a disaster that cannot be accommodated by existing healthcare infrastructure, or a combination of both. 100, 150 or 200 inpatient beds are made available depending on the need, plus acute care, ambulatory care, pediatric care, and behavioral health, each with additional beds available, up to 250 beds total. If patients with complex medical care are unable to be accommodated in the ACF, emergency stabilization measures will be undertaken to allow them to be transported elsewhere.

Examples of reasons for activation:

- An event takes place that stresses hospitals with an increase in patients. The hospitals determine that their best course of action is to move stable or palliative care patients to an ACF so the hospitals can treat more critical patients.
- Infrastructure damage affects two hospitals. Critical patients are diverted to non-damaged hospitals; non-critical patients are sent to an ACF. In extreme circumstances, this may involve diverting patients who have been gravely wounded to allow them to receive assistance in the palliative care unit.

While it is expected that an ACF opened for this purpose will accept walk-in patients as they learn about the facility, the ACF will likely not be publicized to the community as the place to go for medical care. A decision on how best to communicate the purpose of the ACF in any given incident will be discussed at the time the decision to activate is made, and will involve a discussion with leadership and Public Health Communications.

## A. King County Demographics and Vulnerable Populations

King County Washington is the 14th most populous county in the US, with 1.93 million people. King County represents 28.6% of Washington State's population, and as the largest population center in the State poses many opportunities and challenges.

The County includes Seattle, 38 other incorporated cities, and 19 school districts. It is home to the most diverse zip code[1] and the most diverse school district in the nation.[2] Immigrants and refugees from all

[1] AOL News. America's Most Diverse ZIP Code Shows the Way. http://www.aolnews.com/2010/03/25/opinion-americas-most-diverse-zip-code-shows-the-way/

[2] Remade in America. Diversity in the Classroom. *The New York Times*. http://projects.nytimes.com/immigration/enrollment

over the world, including Asia, the Horn of Africa, Central America and the former Soviet Union, reside in King County. 2010 Census data show more than 1 in 3 residents is a person of color, increasing to almost half among children. The county, especially the southern suburbs, includes several cities and school districts in which racial minorities are now the majority population. One out of every five residents (over 420,000 adults and children) now lives below 200% of the federal poverty level. In King County, this translates to 12.7% of the population, or 244,000 people, without insurance[3].

Twenty-three percent of residents speak a language other than English, and 19% are foreign-born. Public Health has identified three language tiers to reflect the language needs of Limited-English Proficient populations. This information will be consulted when the plan is activated to get a better sense of interpretation services needed and languages for ACF material translations. When deciding on interpreter services and translations for ACF's by location, staff will refer to the King County language maps in the Public Health Translation Manual[4].

More information can be found on King County's website:
http://www.kingcounty.gov/healthservices/health/data.aspx and
http://www.kingcounty.gov/healthservices/health/data/maps.aspx

Health Inequities

Over the last two decades, three dramatic demographic changes have taken place in our county, particularly in suburban cities. Because those areas of our county lack adequate systems, policies, and supports to meet challenges, King County has experienced an increase in health inequities that ranks it among the worst of the 15 most populous metropolitan counties in the US.

Additionally, more people in poverty reside in the suburbs than in the urban core[5]. The changes contribute to the high and rising prevalence of chronic disease and risk factors in the suburban cities of northern and southern King County. Those suffering from chronic disease are more vulnerable before, during and after a public health emergency.

While accounting for populations suffering from health inequities, ACFs must be prepared to address the needs of vulnerable populations such as children (requiring pediatric care), medically dependent/medically compromised, physically or developmentally disabled, immigrants, chemical and alcohol dependent, homeless and those who need palliative care and behavioral health services. More information on vulnerable population definitions can be found in the attachments.

Attachments

VP 01 Faith Communities
VP 02 Using Telephone Interpreters
VP 03 Vulnerable Populations Definitions

[3] http://www.insurance.wa.gov/legislative/reports/2011-uninsured-report.pdf
[4] http://kingcounty.gov/healthservices/health/languages/~/media/health/publichealth/documents/translation/PHTranslationManual.ashx Available in Spanish, Vietnamese, Russian, Chinese, Korean and African languages
[5] See Public Health poverty data at http://www.kingcounty.gov/healthservices/health/data/chi2009/SocialPoverty.aspx for more details

## V. Planning Assumptions

1. When an emergency occurs there may be medical needs that exceed the normal surge capacity of existing regional healthcare facilities, or a single facility may be impacted by an isolated incident, rendering it unable to continue housing patients.

2. People with limited access to care on a regular basis may make use of the ACF to seek treatment for chronic conditions not related to the incident that resulted in the activation of an ACF.

3. If the emergency incident is pandemic influenza, approximately 30% of the population will be directly affected, resulting in staffing concerns for an ACF.

4. Some state and federal regulations will need to be waived following an emergency declaration (such as in-state medical licensure requirements).

5. No medical personnel or law enforcement resources beyond local assets will be available for the first 48-72 hours.

6. At all levels of activation, the ACF will provide a capability that will stabilize and accept evacuated patients as required.

7. Behavioral health issues can account for up to 30% of the medical needs after a disaster; up to 20% of the population has had a need for behavioral health medication in the past year.

8. Staff will be pulled from Public Health, the Public Health Reserve Corps (PHRC) and trusted partners such as hospitals and other healthcare facilities.

9. Inpatient healthcare facilities that evacuate to an ACF will provide sufficient medical staff and supplies to support their patients.

10. People may be apprehensive about receiving treatment in an ACF as they may think they will receive sub-par treatment due race, ethnicity or income status. Residents who are undocumented may not want to fill out basic forms for fear that they will be shared with law enforcement.

11. ACF operations must incorporate and address the unique needs and circumstances of vulnerable populations that are economically disadvantaged, homeless, have limited language proficiency, have disabilities (physical, mental, sensory, or cognitive limitations), have special medical needs, experience cultural or geographic isolation, or are vulnerable due to age, as well as those of incarcerated persons. Therefore, specific measures will be taken to ensure that these populations will have accessibility to ACF care.

12. If certain communities are experiencing an increase in health inequities before a disaster, they may be more vulnerable after a disaster and may have a higher need for medical care from the health systems and ACFs.

# VI. Decision-Making

## A. Criteria

The authorization to set up an ACF resides with the Local Health Officer (LHO), who will be in communication with emergency medical services, medical examiner and executives from local hospitals and healthcare agencies as part of the Multi Agency Coordinating group. The ACF will activate only when an emergency exists within the King County region, all other options have been exhausted, and an emergency mission number has been obtained from the State Division of Emergency Management.

Attachments
DM 01 ACF Surge Checklist
DM 02 Surge Information for MAC Group

## B. Notification

In some instances, such as a large-scale emergency, it will be apparent to Public Health that activation of this plan is necessary.

In other circumstances the need for an ACF will not immediately be apparent. In those cases the Public Health Duty Officer will likely be the first point of contact, receiving notification directly from affected facilities. At that time the Public Health Duty Officer will follow the protocol (to be developed) for Public Health notifications found in the Public Health Duty Officer binder.

Attachments
DM 03 Duty Officer Guidelines

## C. Activation of Plan

The LHO will determine, in consultation with the Area Commander and the Multi-Agency Coordinating Group, whether to activate the ACF plan. An ACF will only be opened if the following criteria are met:

- Patient surge cannot be accommodated in existing facilities through provision of additional medical and non-medical supplies
- Patient surge cannot be accommodated by like facilities within King County
- Patient surge cannot be accommodated by like facilities in neighboring counties
- Public Health is able to procure the necessary supplies and staff to safely run an ACF

| Basic Activation Tasks | |
|---|---|
| Public Health | □ Activate Health and Medical Area Command (HMAC).<br>□ Activate Multi Agency Coordinating Group. |
| HMAC | □ Determine ACF units needed.<br>□ Consult site selection sheets to select appropriate location.<br>□ Consult staffing plan to determine immediate ACF staffing needs.<br>□ Consult activation checklist to determine additional needs |
| Affected healthcare facility | □ Activate emergency operations plan. |

Attachment
DM 04 ACF Activation Checklist

Reference
Area Command Operations guide

### D. Command and Control

The ACF will operate under NIMS using the Incident Command System structure. During ACF operations, staff will be identified via the following color scheme:

Incident Commander (AKA ACF Program Manager): Blue
Command Staff (liaison, security, PIO, etc): White
Administration / Finance: Green
Logistics: Yellow
Operations: Red

Health and Medical Area Command (HMAC) will maintain operations to provide administrative, planning and logistical support to the ACF. This may also include standing up an operations section, although most operations will take place at the ACF.

The ACF will operate as its own incident within the overall Area Command structure, with an Incident Commander, and Logistics, Administrative / Finance, Planning and Operations sections. Clinical care will fall under Operations.

Attachments
ORG 01 ACF Scene Org Chart

## VII. Concept of Operations

| Operations Tasks | |
|---|---|
| HMAC | □ Select site.<br>□ Oversee logistics branch tasks, including movement of equipment and signage to ACF site, and procuring needed supplies and services.<br>□ Oversee staffing plan implementation.<br>□ Oversee medical operations branch duties. |
| Public Information Officer (PIO) | □ Provide messaging relevant to patients, potential patients and friends and family. |

### A. Safety

Those tasked with implementing this plan by providing direct care to individuals may face potential health risks, including mental health, risks commensurate with those found in hospitals and long-term-care facilities. In order to protect these workers, HMAC will obtain and provide medical staff

within the ACF with Personal Protective Equipment (PPE), which may include eye, face, head and hand protection, depending on the response. Staff members who may need to use PPE will be trained by their respective agencies in advance of the implementation of this plan, and in any case should use universal precautions. Resources will also be available for staff members who need assistance with stress related to the emergency response.

Attachments

| | |
|---|---|
| SAF 01 Accident form | SAF 02 Emergency Evacuation |
| SAF 03 New Employee Safety Orientation | SAF 04 Personal Protective Equipment and Clothing |
| SAF 05 Personal Safety for Field Worker | SAF 06 Reporting Work-Related Accident Injuries and Illnesses |

**B. Security**

Security is a major priority in determining potential sites for an ACF. As part of the site assessment for ACF locations, a detailed security assessment is conducted and a security plan is outlined. These plans account for both the security of the patients and staff as well as the protection of patients from media intrusion.

Attachments

FAC 04 Security Assessment

**C. Site Selection**

Public Health Logistics staff members identified at least two sites in each of King County's three fire response zones in which to establish a 250 bed facility. Each site will have a binder that will include:

- Power generation capability
- Emergency vehicle access
- Access to kitchen facilities
- Road access
- Security assessment
- Local medical care facilities

Using this information the Operations Section Chief will work with the Area Commander to identify the best location based on the needs of the particular incident.

Attachments

| | |
|---|---|
| FAC 01 Blank Site Analysis | FAC 02 Facilities Ramp up |
| FAC 03 2010 Exhibition Hall Floor Plan | |

Resources

Electronic Facility Information: J:\PHEMRMGMT\HMAC Logistics\Facilities\ACF Sites

## D. Site Set-Up & Internal Communication

1. Site Set-Up

Just in time training documents provide direction to the set-up team including instruction on how to set up beds, nursing stations, triage and check-in. Signs to support way-finding and aid ACF staff members, patients and their family members in navigating the ACF space are available in the ACF supply cache.

2. Internal Communications

The primary mode of voice communication in the ACF is landline, with cellular telephones, 800MHz radios and Amateur Radio used if landlines are unavailable. Phones currently held in the Public Health warehouse can connect to existing land lines.

The primary mode of data communication is email, using mobile email service for brief communication. WATrac, SharePoint and text messaging are alternate options. The ACF will rely on existing on-site wireless or wired internet connections; if those options are unavailable, the ACF will use wireless cards or seek installation of service by vendors.

Attachments

TC 01 CRI Tactical Communications Flow Chart TC 02 Comm Matrix

## E. Accepting Patients

Patients may arrive at an ACF in a variety of ways, depending on the incident and the purpose of the ACF:

- They may be transferred from a critical care facility or the scene of an incident (if it is extended operations, as an ACF will not be opened immediately after an incident) via ambulance (possibly at the direction of the Disaster Medical Control Center (e.g. in surge incident where stable patients are transferred to an ACF to make room for the seriously injured).
- They may be transferred from a long-term care facility via Access transit or ambulance (e.g. when a long-term care facility loses power and must evacuate). Long-term care facilities seeking the opening of an ACF to transfer evacuated patients will work directly with the Nursing Home Team (a component of the Operations Section of HMAC) to ensure ACF staff have a list of patients to be received.
- They may arrive directly from the scene of an incident via ambulance (e.g. in an extended operation incident where the ACF serves as a triage point).
- They may walk in or be brought in by a family member or friend (e.g. after an earthquake someone has a minor injury and has been directed away from overwhelmed hospitals).
- They may arrive with staff from the evacuating facility (e.g. pediatric critical care patients).

Patients arriving through their own volition will line up at the entrance to the facility. Clinicians and behavior health specialists will walk the line to see if anyone is in acute distress or suffering from a potentially infectious condition. In those cases the patients will be brought in immediately and taken through the triage process. All others will remain in line until they can enter and begin the triage process.

Healthcare facilities interested in discharging their patients into ACF care will receive a checklist outlining the care being offered by the specific ACF opened, along with instructions and

requirements the facility must address as a condition of ACF activation (i.e. providing medical staff and supplies to support patient care).

## F. Triage

As discussed above, people may arrive at the ACF via ambulance/transportation from another facility, or of their own volition. Those who arrive via ambulance or from another facility will be accepted via the ambulance bay and triaged into care. Those who arrive on their own will be directed to join the queue to be triaged. If possible, a separate area will be opened to allow those seeking admittance to the ACF to have a place to sit, with groups of patents taken to the ACF for triage and treatment. This is to allow the ill and injured to sit while waiting to be seen. As patients arrive to this area or start to queue up, a triage nurse will be tasked with identifying any patients who may be infectious or may be in such serious condition that they need to be seen immediately. Either this triage nurse or others providing support to the waiting area will also provide these patients with information on the expected wait time, services available, and forms that need to be completed. If possible the area will have water and access to restrooms. Law enforcement will be needed to ensure the security of those waiting for admittance to the ACF.

If the potential patient does not speak English, ACF staff will seek to learn about the person's condition by using (in order of preference) on-site bilingual staff, the language line, or a poster that allows patients to point to the image that best describes their condition.

Triage will take place in two stages. The first will be an immediate screening for patients who are 'red,' meaning they are in very serious condition and must be moved directly to the acute care section of the ACF, where any forms will be fully completed once the patient is stabilized. This area will have wheelchairs and stretchers available to move these patients quickly to the acute care section, although it is most likely that such patients will arrive via ambulance.

Patients not classified as red will be classified as either 'yellow' (possible ambulatory or in-patient) or 'green' (likely ambulatory, although possibly in-patient). Yellow patients will be directed to one waiting area, which will have chairs and cots available, to complete the check-in forms and be more thoroughly triaged to determine where the patient should go and in what priority order. Green patients will be directed to another waiting area, which will have chairs available, to complete the check-in forms and be more thoroughly triaged to determine where the patient should go and in what priority order. All patients who are alert will be asked whether their name may be made available to those inquiring after them in an effort to protect those who may be facing domestic violence or other stalking situations.

During the triage process, at least one staff member (ideally a clinician, but at minimum someone trained in psychological first aid) will be tasked with providing behavioral health support in the secondary triage waiting areas. This may also involve pulling in other staff from the Behavioral Health unit, as well as making use of trained peer support counselors. These staff members will provide support to patients awaiting treatment and will be tasked with looking for any mental health issues the patients are experiencing. This may include chronic or severe issues but is also likely to consist of patients experience anxiety directly related to the current disaster trauma.

The ideal triage staff will include triage nurses and EMTs/medics; however it is understood that staffing will be limited and that may not be possible. As such, PHRC clinicians will be trained on the ACF triage process to be available to serve in that role during an ACF activation.

### G. Patient Care Units

Depending on the incident and the type of ACF opened, there may be a variety of patients and thus a variety of patient care needed, including pediatrics, in-patient, ambulatory, palliative care and post-mortem care. The attached documents gather together the information needed to guide those providing the care in how to best address patient needs within the ACF scope of care. The Medical Director is responsible for developing, implementing and maintaining all aspects of patient care and for making the necessary information available to staff and volunteers via the ICS structure.

Attachments

| | |
|---|---|
| PC 01 Chart Check | PC 02 Standardized hospital codes |
| PC 03 General Care Flow | |
| PF 01 Basic Health History Adult | PF 02 Child Health History |
| PF 03 Consent to Care | PF 04 Patient Registration and Facesheet |
| PF 05 Refusal of Treatment | PF 06 POLST form |
| PF 07 Patient Property | |
| SF 05 Code Documentation Protocol | SF 09 Triage and Treatment Chart |
| SF 13 Patient Identification Form | |
| POL 100 ACF Basic Life Support | POL 101 ACF Blood alcohol testing samples |
| POL 102 ACF Blood Glucose Testing Using Accu-check Inform | POL 103 ACF Cardiac Arrest (Code Blue) Team Protocol |
| POL 104 ACF Child Elderly Abuse and Neglect | POL 105 ACF Cleansing Open Wounds |
| POL 106 ACF Clinical Pathway | POL 107 ACF Code Documentation |
| POL 108 ACF Crash Emergency Carts | POL 109 ACF EMTALA Responding to Emergency Hosp Campus |
| POL 110 ACF OB Patient in ED | POL 111 ACF Sedation Analgesia |
| POL 112 ACF Transcription of Orders | POL 113 ACF Verbal Orders |

CARE UNITS

*Acute Care*

Patients who are in the most severe distress (classified as 'red') will be taken to the acute care area for stabilization. The ideal situation will allow for patients with acute care needs to be transported to a hospital. However, as the need for the activation of the acute care module will likely coincide with limited hospital access, equipment and pharmaceuticals needed to keep acute care patients stable are being procured and maintained in the ACF supply cache. Pediatric patients in need of acute care will be taken to the acute care section as well.

Attachments

ACU 01 Acute care provider guidelines
SF 02 Acute and Inpatient Pre Printed Order Form

*In-Patient*
The in-patient area of the ACF will be organized into sections of ten beds, with a nurse station associated with each of those sections. The main area will include short-term and long-term care areas. Short-term areas are for patients who may only need assistance with hydration or recovery for six or 12 hours. Long-term areas are for patients who will need a longer duration of care in the ACF.

Attachments
SF 02 Acute and Inpatient Pre Printed Order Form

*Ambulatory*
Ambulatory care will be provided to treat wounds and offer other medical services that do not require an extended stay. Once triaged to the ambulatory care section, additional triage staff will determine the order in which those patients are seen to ensure that the most serious ambulatory conditions are treated first.

Attachments
SF 03 Ambulatory Care Pre Printed Order From

*Pediatrics*
When a minor arrives at the ACF, a nurse, preferably with pediatric experience, will be available to either directly perform or oversee triage. If the patient is an unaccompanied minor, that patient will be triaged and treated as indicated. Various attempts will be made to locate a parent or guardian, which may include contacting a Family Assistance Center or shelters (if such facilities are operating). After a specified time period, local law authorities will be notified. A photo will be taken of the patient to assist in reunification with family at a later date.

If it is determined that the patient does not require treatment, he/she will be discharged with follow-up instructions. If the patient does not have an inhabitable dwelling, or if the patient is unaccompanied, a social worker will be contacted to help manage discharge planning.

If it is determined that the patient does require treatment and inpatient care is indicated, the preferred bed assignment will be the pediatrics inpatient unit. However, beds in that unit will be prioritized for infants and young children, so if it is full, older patients may be accommodated in the adult inpatient section. When the patient is determined to be ready for discharge from the ambulatory unit or the pediatric or adult inpatient unit, he/she will be moved either to the palliative care unit, discharged to home or transferred to hospital. If the patient is discharged but does not have an inhabitable dwelling or does not have a parent or guardian available he or she will be directed to the Pediatric Safe Area until a social worker (notified by law enforcement by ACF staff) is able to assist discharge planning. If the patient can be transferred to a hospital, the ACF will work with the hospital to secure transportation.

Attachments
PED 01 Pediatric Flow
PED 02 Pediatric Patient Admitting Procedure
PED 03 Pediatric Security Issues
PED 04 Pediatric Tracking Protocol
PED 05 Pediatric Assessment Triangle Criteria
PED 06 Pediatric Visual Assessment Triangle
PED 10 Asthma Pathway
PED 11 Child Pain Scale
PED 12 Fever Guidelines for Infants
PED 13 Pediatric Rehydration Guidelines

PED 14 Guidelines for Treatment of Dehydration with Oral Rehydration

SF 04 Child ID Form

*Palliative Care*

The palliative care unit will be located in a section of the ACF that allows for a quiet, calm environment. If possible, fans will be available to ensure that the temperature of the area does not lead to the discomfort of the patients. Visiting hours and numbers of visitors will be set to allow family members to visit with their loved ones while ensuring that other patients in the unit are not disturbed.

Palliative care patients may arrive at the ACF from a number of locations and in various states of health:

- They may have been admitted to another ACF unit and over time need to be transferred to palliative care.
- They may have been cared for in the home, which was then destroyed by a disaster.
- Hospitals may find it necessary to transfer palliative care patients to an ACF to free up space for other patients.
- They may be severely injured people for whom there are not sufficient resources to save their lives.

When patients are received into the palliative care unit they will be triaged to ensure that the unit is the appropriate location for them. They will then receive comfort care for the duration of their stay at the ACF. If they die while in ACF care their remains will be handled according to the mortuary affairs procedures.

Attachments

PAL 01 Palliative Care Policy PAL 02 Palliative Care Flow

SF 12 Comfort Care

*Behavioral Health*

In recent disasters, up to 30% of the patients had need for behavioral health treatment. While the ACF is not the appropriate venue for those needing treatment for chronic mental health conditions, it is inevitable that such patients will seek treatment from an ACF. As discussed in the 'special considerations' section of the Scope of this plan, policies are in place to assist those with behavioral health issues who come to the ACF. Ideally this will involve stabilization and transportation to a standing facility better equipped to address these issues; however the ACF will be prepared to assist these patients should the option of transfer not be available. The beds will be considered part of the 'Inpatient' area but will be separated as necessary. Additional beds will be made available in another part of the ACF if isolation is warranted.

Patient behavioral health treatment will include:

- explaining the ACF treatment process to ease anxiety
- ensuring continuity of patient medications
- providing isolation rooms as available
- employing restraints as needed to ensure the safety of the patient
- addressing acute agitation

- alleviating symptoms of chemical dependency withdrawal

The staff that would be asked to serve in the Behavioral Health area includes registered or licensed psychologists, psychiatrists, mental health counselors, social workers, marriage and family therapists, psychiatric nurses and school nurses. Additionally, spiritual care workers, peer counselors and others with relevant training will be asked to assist as well. Ideally these staff members will be previously credentialed through the PHRC or other recognized credentialing systems (e.g. ESAR-VIP). They may also come from the Red Cross Mental Health Team; King County Mental Health, Chemical Abuse and Dependency Services Division Outreach Team; or Green Cross.

Behavioral Health

BH 01 Mental Health Services
BH 02 Med Surgical Restraint Order
BH 03 Non-Violent Non-Self Destructive Restraints
BH 04 Opioid Treatment MOA

*Mortuary Affairs*

If needed, the ACF will include temporary morgue service to allow for bodies to be kept on site until they can be removed as the law allows. Detailed instruction as to how to manage mortuary affairs can be found in the ACF Morgue attachment, which includes information on handling of decedents, decedent identification and management of personal property.

While family members of decedents may express a strong desire to view the decedent after death, the ACF will not be able to accommodate such requests. Viewing will not take place at the ACF.

Attachments

MOR 01 Morgue Operations

MEDICAL SUPPORT

*Infection Prevention*

Infection prevention and control will be a concern at the ACF, as it is for hospitals and other medical service providers. The ACF will exercise as much caution as possible to protect both the infectious patients and those who risk exposure.

Infection prevention will start with the line of patients seeking treatment from the ACF. It is anticipated that lines for triage and admission will extend outside of the ACF building, and in that line people will be in close proximity to one another. A triage nurse will be tasked with walking along the line in an attempt to spot potentially infectious patients.

The first goal in dealing with infectious patients is to send them to a hospital; however it is highly unlikely that this option will be available if an ACF has been set up in a disaster situation. Instead, suspected infectious patients will go straight from triage to admission, skipping check-in. If the patient is expected to need in-patient care, the patient will be moved to an adjacent but isolated facility for treatment. If the patient only needs ambulatory care, he or she will be moved to an established isolation area of the ambulatory care section. Clinical staff will follow best practices infection control in order to minimize infection transmission.

Sanitary conditions will be maintained at the ACF to prevent individuals from becoming ill due to environmental factors. Janitorial staff will be instructed on how to properly clean areas where isolated patients have been treated so as to reduce the spread of infection.

Attachments

IPC 01 Alternative methods of surgical scrub
IPC 02 Antiseptics and Disinfectants
IPC 03 Aseptic Technique
IPC 04 Blood borne Pathogens Exposure control
IPC 05 Disposal of Sharps
IPC 06 Enzymatic Cleaning Sterilization or High Level Disinfection
IPC 07 Exposure Control Plan
IPC 08 Hand washing
IPC 09 Hazmat guide
IPC 10 Housekeeping
IPC 11 How to Make a chlorine solution
IPC 12 How to perform surgical scrub
IPC 13 Infection Control in a Communicable Disease Emergency
IPC 14 Infection Prevention Flow
IPC 15 Infection Prevention Quick Reference
IPC 16 N95 mask usage
IPC 17 Post Exposure Prophylaxis
IPC 18 Processing Instruments and Other Items
IPC 19 Putting on and removing sterile surgical gloves
IPC 20 Putting on sterile surgical gloves
IPC 21 Quick Guide End Isolation
IPC 22 Rapid 1 to 2 Person Decontamination
IPC 23 Steps of Chemical Sterilization
IPC 24 Steps of Cleaning
IPC 25 Steps of High Level Disinfection by Boiling
IPC 26 Steps of HLD by Chemical
IPC 27 Steps of Steam Sterilization
IPC 28 Substantial Exposure Policy
IPC 29 Transmission Precautions Quick Guide
IPC 30 Use and Disposal of Sharps
IPC 31 Use of Gloves

*Oxygen*

Public Health has multiple oxygen delivery options that allow it to provide a scalable oxygen capability in ACF response. Current capabilities include the MedLox MODS 75 Oxygen Distribution System, a cache of H-tanks and a cache of National Oxygen Kits (NOK).

The ACF will use the cache of H-tanks and NOK carts to provide an initial oxygen capability. This approach will sustain the oxygen demand while awaiting delivery of liquid oxygen to support the larger capacity MedLox system. The H-tanks and NOK carts also allow the option to operate solely off of them if the larger capacity MedLox system is not required. Each of these options allows the ACF to operate without electricity. Public Health has various lengths of oxygen hoses to help expedite the set-up process.

Attachments

FAC 30 MODS Features Benefits
FAC 31 Oxygen Options

*Medication Reconciliation*

Just in time training will be given to all ACF clinicians to ensure that they are aware of the issue of medication reconciliation, which seeks to avoid inconsistencies in transition of care. The goal is to gather and track all the necessary information from patients.

*Patient Decontamination*

It is highly unlikely that gross decontamination will take place at the ACF. However, there may be instances where one or two people are exposed to contaminants and arrive at the ACF. In those instances, basic protocols (outlined in the Patient Decontamination attachment) will be followed to allow those patients to be decontaminated while preserving the safety of those seeking treatment at the ACF.

*Pharmacy*

In order to accommodate the pharmaceutical needs of the patients of the ACF, a Pharmacy will be open 24-hours a day for the duration of ACF operations. The Pharmacy will provide medication for in-patient and ambulatory care patients but will not serve as a location where people who are not ACF patients can come to refill prescriptions.

Pharmacy staff will consist of a combination of pharmacists, pharmacy technicians, pharmacy students and other volunteers, and will be drawn from Public Health Reserve Corps, UW School of Pharmacy, and/or other sources of volunteers.

Attachments

PHR 01 ACF Rx Ops Plan
PHR 04 ACF Rx Cache
PHR 05 Palliative Medicine recommendation
PHR 06 Providence Comfort Kit Costs
PHR 07 Vaccine Storage and Handling Plan
PHR 08 Flu Vaccine Procedure
PHR 09 Pediatric Pharmacy Annex
PHR 10 Pharmacy Database
PHR 11 Perpetual Inventory

SF 10 Medication Admin Record
SF 11 Medication Orders
SF 14 Pediatric Rx Form

*Laboratory and Medical Imaging*

The laboratory tests available in the ACF include:

- HemoCue – white blood cells
- I-Stat – chemistry
- Glucometer – glucose levels
- Mindray – Ultrasound

Lab and imaging work will be conducted by nurses at bedside, with privacy screens brought in when possible. A table or cart will be set up near the in-patient area to allow relevant lab work equipment and supplies to be readily accessible.

Information on how to use or operate the tests and imaging equipment will be found in the just-in-time training binders available in all ACF patient care units.

An X-ray machine has not been purchased; if needed it will be leased.

Attachments

LAB 01 HemoCue WBC Handout
LAB 02 I-Stat Hand out
LAB 03 Mindray Handout

*Equipment*

All equipment and supplies that have been purchased for the ACF are stored in locations throughout the county. Supplies that have an expiration date are kept in limited quantities; expanded amounts will be procured through just-in-time inventory management with vendors.

In order to meet additional equipment and supply needs Public Health – via the HMAC Logistics Section – will use existing contracts or emergency contract powers as needed to contract with companies specializing in providing such equipment and supplies. The HMAC Logistics Section will contact the contracted organizations to secure the needed equipment and supplies. Should the contracted organizations be unavailable, the HMAC Logistics Section will use King County or State vendors. HMAC Logistics will also coordinate with local healthcare facilities during a disaster to determine if they have needed equipment and supplies to support ACF activation, especially for the initial 24 hours of activation.

Attachments

SUP 01 ACF modules 2011 final
SUP 02 Equipment and Supplies Have and Need
SUP 03 Local Emergency Management
SF 01 ACF Supply Request Form

*Point of Dispensing (POD)*

If the ACF is opened due to an incident that also necessitates mass prophylaxis, it is expected that members of the community may come to the ACF to receive their doses. The ACF will operate as a private medication center, meaning that ACF staff and, those patients being treated, as well as their family members, will receive the prophylaxis. Those who come to the ACF seeking medications but do not require treatment at the ACF for an injury or illness will be directed to a pharmacy or public medication center.

## H. Patient Care – Non-Medical Services

In addition to addressing a patient's medical needs, an ACF needs to account for feeding patients, addressing their sanitary needs, and cleaning the linens and facilities.

*Feeding*

Patients, and possibly their accompanying family members, will need to be fed multiple times a day for the duration of ACF operations. Depending on the type of ACF opened, the nutritional needs of the patients will vary, requiring menus that might be low-sodium, 'heart-healthy' or composed in such a way as to assist kidney patients in going longer between dialysis sessions. Staff members will also need to be fed on-site.

In order to meet patient and staff feeding needs Public Health – via the HMAC Logistics Section – will use existing contracts or emergency contract powers as needed to contract with companies specializing in providing such support services to emergency facilities and scenes. The HMAC Logistics Section will contact two organizations outside King County that are currently the Public Health choices for providing this service. Should both organizations be unavailable, the HMAC Logistics Section will either use on-site cooking staff or contact State emergency vendors.

Attachments

FOOD 01 Feeding Distribution Information
FOOD 20 Menu and Calorie Needs

FOOD 21 Public Health Feeding Requirements
FOOD 22 King County Sample Menu 14 day
FOOD 23 PHSKC Price Quote 2010
FOOD 24 OKS Cascade 14 Day Sample Menu
FOOD 25 RE Menus
FOOD 26 Cardiac - Heart Healthy Diet
FOOD 27 Comfort - Low Fiber Diet
FOOD 28 Low Sodium Diet
FOOD 29 Regular Diet
FOOD 30 Feed plan support
FOOD 31 Feed plan

*Sanitary Needs*
While sites included on the list of potential ACF locations have adequate toilet facilities, there will still likely be a need to contract out for additional sanitary stations that can accommodate a variety of people, including those who will need assistance in accessing the facilities. There is also a need to contract for bathing facilities that are accessible to those with mobility challenges. During an ACF activation the HMAC Logistics Section will be responsible for working with ACF Command to determine additional sanitation needs and contracting with vendors to provide those services. The HMAC Logistics Section maintains a list of King County and State vendors who can meet these needs.

*Laundry and Janitorial*
HMAC will contract for medical janitorial services within the ACF. Staff will receive infection prevention training, including bio hazard precaution.

*Telephone and Mobile Phone Service*
During an incident requiring an ACF, patients will want to be in touch with their loved ones. While Public Health recognizes this, it is unlikely that there will be many land-line phones available for patients to use, and the phones that are available will be limited to local calls only. Additionally because of concerns surrounding both equipment interference and privacy of fellow patients, cell phones will not be permitted to be used in the patient care area. In order to facilitate communication where possible, Public Health will set aside space in the ACF dedicated to patient cell phone use.

## I. Policies

*Visitors*
Visitors will be allowed in the ACF provided they are able to assist and do not impede patient care. Visitors may be asked to leave at any time, and while special circumstances may require adjustment of these policies, as a general rule in-patient areas will be limited to two visitors per patient and ambulatory care areas will be limited to one visitor per patient.

*Pets*
Non-service animals are not allowed at the ACF. Any non-service animals arriving with their owners will be taken into care by ESF 6 representatives. Further information on the preparations made to address this issue can be found in the King County Comprehensive Emergency Management Plan, page 119 (January 2011).

Service animals may stay with patients so long as the patients are able to provide for their care, including walking or arranging for them to be walked. If the patient does not have access to food or other supplies for the service animal, ACF logistics staff may use the agency purchasing card to procure supplies to allow the service animal to stay with the patient. If the patient is unable to

arrange for the service animal to be walked, the service animal will be taken into care by ESF 6 representatives.

*Pediatric Safe Area*
Because the ACF environment will not always be safe for young children, particularly those who are unsupervised, a pediatric safe area will be established to meet the non-medical needs of children. There are a variety of reasons that children may need non-medical care at an ACF, including:

- Child whose parent is being seen in ambulatory care and will be released soon
- Child whose parent is being admitted and is waiting for social services / another parent to come get them
- Child who is visiting a relative
- Child arrives unaccompanied or with someone who is not a legal representative and who is cleared for discharge, but is awaiting disposition
- Children of essential or critical volunteer staff who have no recourse other than to bring their children to the ACF.

In order to accommodate these children the ACF will have a Pediatric Safe Area (PSA). The area will be located away from the main ACF floor and will provide a space suitable for children age zero through 14. It is expected that staff from a community agency via an MOU will provide child care in the ACF.

Attachments
PED 20 Children of Patients and Staff PED 21 Pediatric Safe Are Tasks

*Concerned Citizens*
It is expected that some of those who seek assistance from the ACF will be experience anxiety related to the trauma of the incident. While they may or may not need assistance with physical ailments, their concerns are serious and warrant assistance from ACF staff. Behavioral health staff and other trained in behavioral health calming techniques will be available to assist these patients in moderating their anxiety and stress.

Attachments
POL 01 Service and Non-Service Animals POL 02 Visitor Policy

## J. Patient Movement through the ACF: Admission to Discharge

Transportation to and from ACF will depend on the condition of the patients, and may include ambulance, cabulance, Access-a-Ride, Metro buses, private taxis or the private vehicles of the patients' families or friends. The transportation needs of patients being discharged to home or another facility will be addressed by the Discharge Planning Unit.

*Admission*
When patients are admitted to the ACF, they will be asked to complete multiple forms, depending on their triage. For patients with limited English proficiency, staff will work to secure interpretation services. Until that time, forms will be filled out with as much basic information as possible, with details completed later.

Attachments

PT 01 ACF Patient Transfer - DMCC Role

*Patient tracking*
Patients will receive an identifying number when they are seen at triage (if one has not been assigned by EMS in the field). That number will accompany them throughout their time in the ACF, and will be noted on all paperwork related to that patient.

The following forms will be provided to patients and/or used by clinicians to ensure high-quality patient care:

1. Patient Registration and Facesheet: Contains the most basic information about the patient. It would be completed by the patient or someone accompanying them, and could be completed after admission if the patient is not able to fill it out at the time of admission.
2. Consent to Care: Completed by the patient or their legal guardian to allow them to receive treatment in the ACF.
3. Patient Valuables: Basic form that requires two staff members to sign off on the acceptance of patient valuables.
4. Health History / Pediatric Health History: Completed by the patient (or legal guardian in the case of minors). Requests very basic health information. Only patients likely to be triaged to Green or Yellow will complete this form.
5. Rapid Assessment: Completed by Triage clinicians. Includes basic vitals, description of injury/chief complaint, pain score, basic assessment and disposition (Green, Yellow, Red).
6. Medical History: Completed by Green and Yellow patients as a way to provide additional background information to aid in further triage and treatment.
7. Treatment: Completed by Clinicians treating patient. Includes space for additional diagnoses and instruction.
8. Discharge: In most ambulatory and some in-patient scenarios, a version of this form that has been pre-populated will be used to provide discharge instructions to patients. For more complicated discharges, a blank form will be used.
9. Transfer: This paperwork is completed for patients who need to be moved from the ACF to another facility or to home with home health or in home care.

The master list of patients who have been seen in the ACF will be kept at the check-in area located at Step 2, which is where patients are split between the three triage levels. The information will be kept electronically and in paper form. As patients leave the facility via Step 3 or via a transfer, that information will be logged on another form. On a regular basis staff at those locations will come to the Step 2 location to reconcile the data.

Each unit will have a clerk who will be responsible for keeping a running list of patients who have been admitted. The information of patients currently in the unit will be kept on a white board; patients will also be listed on a sheet so that there is a record of what patients have been there previous before being moved/discharged/transferred.

<u>Attachments</u>
PT 01 ACF Patient Transfer - DMCC Role
PT 02 Master Patient Tracking List by Unit
PT 03 Master Patient Tracking List
PT 04 Patient Identification Policy
PT 05 Patient Transfer Healthcare Facility to ACF Checklist
PT 06 Property Tracking List

*Patient discharge and transfer – DPU*
The Discharge Planning Unit (DPU) will be responsible for ensuring that the patient has the needed support to meet any discharge instructions provided by the clinician. This may include securing home health or home care assistance or durable medical equipment. As this is a very specialized task, HMAC Finance & Administration will seek to secure discharge planners from hospitals and long-term care facilities to serve in this role.

If internet service is available, the DPU will use the Crisis Center's website search function to find information on specific resources. Additionally, as more survey information related to the services offered at hospitals and long-term care facilities becomes available, WATrac will serve as a resource for discharge planners seeking placement for discharged patients. DPU will also be responsible managing patient transfer to other facilities, either when space becomes available or when the ACF closes.

While Public Health will work to secure all necessary information for discharging patients back out of the ACF to healthcare facilities, it is expected that hospitals will accept such transfers even if the circumstances are not ideal.

Attachments

| | |
|---|---|
| SF 07 Discharge Summary for Common Issues | SF 08 Discharge Summary for Non Common Issues |

*Patient discharge and transfer – Process*
When a patient is to be discharged home, the DPU will attempt contact with family and assess the ability of home caregivers to resume care of the patient. Discharge will be delayed for persons who are too weak to provide care for themselves or if they have no one to assist them or circumstances obstruct adequate home care. If admission pressure on the facility is high, the facility may choose to move the patient to another part of the facility where a single worker can provide assisted living type care to a large number of persons or to a general population shelter.

The facility will discharge patients when:
1. Deceased;
2. Patient is medically stable or able to be cared for by an available home care provider;
3. Patient is able to care for self if no home care provider is available; or,
4. To a hospital to receive a higher level of care

Criteria for discharge to a home care provider will be:
1. Patient is clinically recovering and afebrile;
2. Patient is able to take food, fluids and usual medications by mouth (or NGT); and,
3. Patient has a place to go suitable for their level of recovery debility.

A patient may be discharged at the request of next of kin regardless of their physical status (i.e., patients will not be held against their will or against the will of their next of kin) upon signing an "Against Medical Advice (AMA)" release. Upon discharge, the patient/caregiver will be provided with instructions on additional care and signs of secondary complications or reasons to bring the patient back.

Before a patient is transferred between facilities, confirmation of acceptance by the receiving facility is required, and DMCC will be notified. This activity should be accomplished by the Discharge Planning Unit. If the ACF requires transfer of a patient to a hospital, the receiving hospital must approve the transfer in conjunction with DMCC. The ACF will accept transfers as long as there is staffed space available to receive the additional patients; however, the medical director for the hospital should confirm with the ACF Medical Branch Director before sending a patient to the ACF through DMCC.

Transportation of the patient between facilities will be the responsibility of the sending entity. Ambulance transport, while preferred, is unlikely to be available to the extent needed. Family members should be requested to move the patient; however, if the family is unable or unwilling, any vehicle driven by a volunteer in which the patient may be recumbent will be suitable. A vehicle suitable for patient transport may be requested from the local EOC if necessary by HMAC.

Documentation accompanying the patient on transfer should include history and physical, current medications being administered as well as those usually taken, personal items and personal care items, medications from home (if available), and routine care appliances (foley catheter, IV or heparin lock). Patients requiring "advanced life support" will not be accepted by the ACF. If the family does not transport, the family should be notified, if possible, of the transfer. The patient location should be updated in the MAP patient tracking system and documented in ACF records. Whenever possible, only copies of ACF records will be sent with transferred patients.

Each shift, the Medical Branch Director going off service should review with the incoming medical director and discharge planner the list of patients which he or she believes might require transfer to a hospital. At least once per day, the Medical Branch Director should discuss these patients with the hospital medical director and request next available bed for these patients. Patients who will be considered optimal candidates for transfer are those who will be expected to have a substantially increased likelihood of survival if admitted to the hospital. This assessment may take into account a patient's underlying medical conditions, age, and nutritional status in assessing survival chances.

Attachments
DIS 01 Case Management Needs Outline DIS 02 Discharge Resources
DIS 03 Patient Transfer and Discharge Checklist

*Medical Records*
Medical records will be kept on file as per applicable state and federal regulations. Anyone who is seen in the ACF and has also been seen in a Public Health clinic previously will have their ACF records added to their patient files. Anyone who has not been previously seen at a Public Health clinic will have their records stored at the clinic nearest to their home.

Attachments
MR 01 ACF Medical Records Retention

## K. Community Partnerships

Establishing and operating an ACF requires the participation and support of a number of community partners and stakeholders. The roles of these partners may change depending on the incident, but some examples include:

- Public Health will work with local emergency management to coordinate access to location and information on existing roads and infrastructure.
- Public Health and the Northwest Healthcare Response Network's will work participating hospitals and healthcare facilities to provide medical staff, coordinate patient care, and oversee admission and discharge planning.
- Trusted partners, including hospitals, community-based organizations and faith-based organizations may be called upon to provide staff with expertise in providing services such as those offered in the ACF.

## L. Additional Assets

1. Mutual Aid

ACF operations will seek to pull from in-county assets as much as possible. However, especially as it pertains to staffing, this may not be feasible. As such, the Finance and Administration section may seek mutual aid assistance in filling some roles, including clinical and non-clinical staff.

2. State and Federal Assets

Should the ACF require additional assistance beyond the resources available within the region or via mutual aid, HMAC will request assistance from King County Regional Coordination and Emergency Communication Center (RCECC) in locating additional assets. HMAC may make requests for emergency contracting assistance and for staffing, but will rely on the RCECC to request from the state any resources they are not able to secure. If the state is unable to secure those assets, HMAC will rely on the State to request federal support, which may include Disaster Medical Assistance Teams.

| Potential Federal Resources | |
|---|---|
| USPHS Commissioned Corps (USPHS) | □ Mental Health Team (MHT)<br>○ Mental and behavioral health experts who assess stress and suicide risks within the affected population |
| National Disaster Medical System (NDMS) | □ Disaster Medical Assistance Teams (DMATs)<br>○ Up to 35 clinicians<br>○ Self-sufficient for 72 hours<br>○ Includes physicians, nurse practitioners, physician assistants, nurses, pharmacists, respiratory therapists, paramedics, EMTs and others.<br>□ International Medical Surgical Response Teams (IMSuRTs)<br>○ 50-member teams<br>○ Come with equipment and supplies (including pharmaceuticals and blood)<br>○ Have a mobile field hospital<br>○ Provide acute care, operative care, critical care and |

| | |
|---|---|
| | evacuation at fixed and mobile hospital facilities<br>□ Patient Evacuation<br>o Casualty Collection Points (CCPs) that feed into State-operated Aerial Points of Embarkation (APOE). |
| Federal Medical Station | □ 100 personnel need to staff it<br>□ Three-day supply of medical and pharmaceutical resources for 250 stable patients |

**M. Staffing**

An ACF will have the necessary professional health care staffing consisting of healthcare personnel from evacuating facilities; licensed healthcare personnel currently working in other local healthcare facilities; retired licensed healthcare personnel who are registered as Public health Reserve Corps members; registered volunteers from other counties in Washington; and Public Health department staff. Additionally, non-clinical staff will fill non-medical-care roles.

The HMAC Finance and Administration Section (F & A) is responsible for recruiting, credentialing, and developing Just-In-Time training for volunteer staff. The F & A Section Chief will recruit and fill positions in support of the ACF deployment plan, and will also recruit those professions identified in the Emergency System of Advanced Registration of Volunteer Health Professionals (ESAR-VHP) and the Public Health Reserve Corps. Volunteers will be registered as emergency workers for the purposes of liability protection.

HMAC will establish a Public Health Activation Center to coordinate recruitment and mobilization of staffing for an ACF. When staff members have checked in to the Public Health Activation Center they will receive overall orientation and role-specific training, then be directed to the ACF, where the Planning Section Chief will send staff to meet up with the respective section chief.

In addition to Public Health staff and PHRC volunteers, two additional categories of staff exist: trusted partners and spontaneous unregistered volunteers. Staff from healthcare facilities who have been through a background check are considered trusted partners and would be registered at the time of deployment as emergency workers.. Spontaneous volunteers will need to be checked before they can assist; in an emergency they may not be able to be accommodated in the ACF staffing plan.

Attachments

STF 01 Process Request Staff
STF 02 Staff Request Form
STF 03 Staff Request Grid
STF 04 Hospital Checklist Sending Staff
STF 05 Time Sheet
STF 06 Staffing FAQ

**N. Logistics Section**

ACF Logistics is responsible for managing the on-site inventory of all non-medical and medical (but non-pharmaceutical) supplies and equipment. The first choice for the ACF Logistics Section is to manage inventory electronically, using a combination of a stand-alone Excel spreadsheet, WATrac, and the Oracle system. ACF Logistics staff will be responsible for tracking the flow of inventory

from the on-site store into the ACF, as well as requests for additional supplies. HMAC Logistics will be responsible for ensuring that ACF Logistics and off-site distribution centers records match up.

The Logistics Section will use the attached documents to inform their procurement of necessary supplies and services. Following ICS structure and the attached flow charts, the ACF Logistics Section Chief will request medical and non-medical materials and resources via the HMAC Logistics and Finance & Administration Sections, who will work together to procure needed resources. HMAC will work with the county and state to obtain equipment and supplies that are not available locally.

Attachments

| | |
|---|---|
| LOG 01 Logistic requests | LOG 02 Logistic requests food janitorial |
| LOG 03 Process Request Goods Services | |
| FAC 20 Logistics Section Contract List | FAC 21 State EMD Planning Logistics Vendors |

**O. Finance and Administration Section**

The HMAC and ACF Finance and Administration (F & A) sections will provide support to ACF via the processes outlined in the HMAC ESF 8 Basic Plan and EOC functional annex in conjunction with the Volunteer Management Center and Workforce Management plans. The majority of F & A staff will work at HMAC, with minimal staff on location at the ACF.

*Staffing*

The Public Health Activation Center (PHAC) Plan will be activated to provide staff for the ACF. The PHAC Supervisor is responsible for fulfilling mission requests for additional staff. The Supervisor's first task will be contacting PHSKC employees to determine availability. After staff have been contacted and instructed to respond with availability within a specified time period, PHRC volunteers will be contacted via the WA Respond telephone or e-mail systems. Evacuating healthcare facilities will be contacted to confirm that they will provide medical staff for the ACF. Volunteers are categorized by licensing (R.N., MD, etc) as well as location, making it possible to activate only those geographically near to the ACF or with the skills needed depending on the size and type of ACF opened.

All staff and volunteers who will be providing assistance at any locations will be required to report to the PHAC each day. Once they are checked in and have received their orientation and just in time training they will either be bussed or will make their own way to the site at which they are working. At the end of the day the process will be reversed, with all staff and volunteers returning to the PHAC and checking out before returning home. Regardless of the origination of the need, ALL requests for additional staff not already working for the requesting department must go through the HMAC.

The F & A Section will have responsibility for ensuring that time sheet reconciliation is managed, as well as providing forms that need to be completed to report things like workplace injuries. Staff members tasked with this responsibility will be located at the ACF site and not at HMAC.

Additionally, the Section will be responsible for ensuring that the staff members working on the incident have access to resources to address any mental health concerns they have related to the stress of the tasks they perform.

Attachments
Job Checklists

*Procurement*
All requests that require purchase approval will be managed by HMAC F & A. Requests will be received by the ACF Logistics Section, which will determine whether the requested supplies are available on-site or from existing inventory. If the supplies are unavailable, ACF Logistics will send the request to the HMAC Administration and Finance section, which will determine whether to sign off on the request. Once the amount of funding available is officially communicated, the HMAC Logistics section will work to procure the requested supplies. This process is outlined in the attached flow charts.

*Reimbursement*
The F & A section will be responsible for tracking and cataloguing all expenses during ACF activation. This includes supplies/equipment/medications (including items that had been purchased previously as well as newly purchased items) and any contract costs. The F & A section will work with King County ECC, following their direction and procedures for collecting and submitting the necessary information.

Additional reimbursement may be available from CMS, depending on the incident and the nature of the activation.

Attachments
FA 01 MOU and Contract list

**P. Planning Section**

Planning section staff on site will likely be limited to a Section Chief. This person will be responsible for staff check-in and check-out, as well as for providing any on-scene planning support, including demobilization.

Attachments
PLN 01 Demobilization

**Q. Plan Demobilization**

As the need for an ACF decreases and inpatient healthcare facilities are able to address patient care needs, HMAC staff will begin preparations for demobilization.

If Federal Medical Stations (FMS) has provided relief for staff and assumed responsibility for the ACF, HMAC logistics branch will work with FMS to inventory, repack and recover ACF equipment and supplies.

| Demobilization Tasks | |
|---|---|
| Public Health Area | □ Work with HMAC Planning Section to prepare |

| | |
|---|---|
| Command | demobilization plan. |
| Public Information Officer | □ Alert the public and healthcare partners that patients are no longer being accepted to the ACF / patients are being discharged or returned to their original places of treatment. |
| Healthcare Community | □ Accept patients being discharged / in need of follow-up care |

## VIII. Public Communications

The main goal for public information during the activation of an ACF is to help the public understand what an ACF is, including what to expect. When an ACF is activated, the Public Information Officer will issue a press release in multiple languages, and shared via the vulnerable populations' advisory team and healthcare public information officers. If necessary, a public information call center will be activated to take calls from members of the public who have questions. The comic strip that was developed by the department will be shared to help people understand how ACFs work.

When the ACF is in the process of opening, Public Health PIOs may schedule a controlled media availability to assist in getting information out. Once that is finished, media will no longer be allowed to access the ACF. If there is not a PIO on site, there will be a designated person – likely the ACF Incident Commander – assigned to respond to media requests by directing them to the Communications section.

Reference
Public Health Communications Plan

## IX. Responsibilities

Lead Agency:
Public Health Seattle & King County

- Activate ACF Plan
- Secure location for ACF
- Secure necessary supplies, equipment and medication
- Provide support staff
- Secure clinical and non-clinical staff

Supporting Agencies:
Local Healthcare Facilities

- Ensure any patients transferred to the ACF have medical records with them
- Provide staff to the ACF as requested and as available
- Accept discharged patients from the ACF

King County Regional Coordination and Emergency Communications Center

- Assist in securing medical and non-medical supplies and services as requested by HMAC

Local Emergency Operations Centers

- Assist in securing non-medical supplies and services as requested by HMAC

Emergency Medical Services

- Provide staff to the ACF as requested and as available
- Transport patients to and from the ACF as needed

## X. Authorities

The need to stand up an Alternate Care Facility will be determined by and operate under the authority of the Local Health Officer.

The Local Health Officer acts under the direction of the local Board of Health. RCW 70.05.070. The Local Health Officer enforces the public health statutes, rules and regulations of the state and the local Board of Health. RCW 70.05.070(1).

## XI. References and Resources

U.S. Census Bureau 2009 Estimate - http://quickfacts.census.gov/qfd/states/53/53033.html

Attachments

RES 01 Points of Dispensing AJIC
RES 02 Role of IP in Emergency Management
RES 03 Shelters Disasters
RES 10 Hospital Mass Fatality Planning Slides
RES 20 Care Logs
RES 21 Comfort Care 1
RES 22 Comfort Care 2 and 3
RES 23 Comfort Care 4
RES 24 Comfort Care 5
RES 25 Comfort Care 6
RES 26 Comfort Care 7
RES 27 POLST Fact Sheet
RES 30 Pediatric Pharmacy Presentation
RES 31 Hospital Surge Capacity
RES 32 Every Kid Every Time for Inpatient Final
RES 33 Pediatric Toolkit

## XII. Public Health Emergency Preparedness Capabilities

Mass Care
Medical Countermeasure Dispensing
Medical Materiel Management and Distribution
Medical Surge
Volunteer Management

## XIII. Training & Exercises

- PHSKC Preparedness Staff will receive an orientation of the plan each time significant revisions are made.
- Potential ACF staff, including hospital staff and PHRC volunteers, will receive topical training on different sections of the plan, including pharmacy, equipment and logistics.
- Facilitated discussions or table-top exercises will be scheduled at regular intervals to validate different components of the plan.

- A functional or full-scale exercise will be held every other year as funding allows or as directed by grant requirements. The next full-scale exercise will be held before 2015.

## XIV. Plan Maintenance

The ACF plan and its attachments will be maintained by the Preparedness Section of PHSKC. Edits to operational documents are ongoing; the plan in its entirety will be reviewed and revised every three years. The next revision is scheduled for 2015.